b) generating a bill for the individual, said bill listing every service provided over the predetermined time period for the individual and related people and said bill providing a total amount due for the aggregated claims.

14. (New) A method of administering a healthcare plan, comprising the steps of:
a) aggregating all claims from providers resulting from service supplied over a predetermined period of time to all persons covered by the plan; and
b) generating a bill for the plan sponsor, said bill identifying a total amount due from the sponsor for the aggregated claims.

REMARKS

Pending Claims:

Entry of these amendments is respectfully requested. Upon entry of this amendment, claims 1-14 will be pending. Claims 1, 2, 3, 5, 7, and 8 are amended by this Response. Claims 9-14 have been added.

New Claims:

Claims 9-14 are new claims. Consideration of these claims is respectfully requested. These claims are supported by the specification as originally filed.

Drawings:

The informal drawings submitted with the application were objected to in the Office Action.

Rejection under 35 U.S.C. §112, Second Paragraph

Claim 8 is rejected under 35 U.S.C. §112, second paragraph due to confusion regarding the use of "fourth means" and "fifth means". The Applicants have amended claim 8 to recite "six" and "seventh" means to address the Examiner's concern.

Rejections under 35 U.S.C. §102(e) – Claims 1-8

The Examiner has rejected claims 1-8 as being anticipated by Freeman, U.S. Pat. No. 6,012,035. Without admitting or concurring that Freeman constitutes prior art under 35 U.S.C. §102(e), the Applicants offer the following comments regarding Freeman and the claimed subject matter.

The Applicants' system and method represent a revolutionary way of processing health care claims. The Applicants describe the aggregation of batches of claims over a predetermined period of time. This batching or aggregation of health care claims yields significant advantages in a streamlined process that minimizes the number of data and money exchanges that must occur. Further, this aggregation approach yields data summaries that are easy for patient/employees, employers, and providers to understand. Specifically, the Applicants teach that an administrator pays a provider in a lump sum for an aggregate batch of claims for services rendered during a predetermined time period.

In another aspect of this batching approach, employees receive one monthly bill or statement that lists all of the services received by an employee and his/her family members during a predetermined period of time, such as one month. This single bill identifies a total amount due by the employee for all of the claims for the predetermined period. Thus, the employee has only one bill to pay for all services received by all of the family members during the time period, regardless of how many providers delivered service for the family members and regardless of how many family members received services. This approach is in stark contrast to current practice (and to Freeman's approach as will be discussed below). In current practice, the employee receives separate bills for services rendered to each patient/family member and in many cases, every provider submits a separate bill, even where more than one provider has assisted with one medical episode. For example, a cancer surgery could yield bills from the hospital, the surgeon, the anesthesiologist, the oncologist, the lab, the X-ray technician, the phlebotomist, and so on.

Still another aspect of this aggregation approach involves aggregating a batch of claims for the plan sponsor. The administrator aggregates claims for services rendered over a predetermined period of time to all people covered by the plan . The administrator submits to the plan sponsor (the employer, in an employer self-insured

setting) a request identifying a lump sum amount owed for the batch of aggregated claims.

In contrast, Freeman describes a transactional approach whereby the processing of individual claims is automated. This focus on individual claim processing teaches away from Applicants' approach of aggregating claims to reduce the number of transactions (data and money transfers) that occur between the parties. By automating the processing of each individual claim, across several entities via computer networking, Freeman acquiesces to the typical practice of transactional or individual, rather than aggregate, claim processing. Specifically, Freeman does not show or suggest paying the providers for an aggregation of claims for services rendered over a predetermined period of time. Rather, Freeman describes the payment to the provider for each claim: "Once the insurance company adjudicates the claim, the provider is fully reimbursed by the bank for the claim, minus the service charge." Col. 7, lines 6-8. Also, "In step 108, the insurance company adjudicates the claim and directs the bank to pay the doctor." Col. 8, lines 21-23. And, "The bank pays the claim amount . . .". Col 8, lines 26-27. Emphasis is added in all of the above Freeman quotes. Further, from the overall description of Freeman, it will be understood that Freeman teaches the immediate networked processing of each claim when a service is rendered by a doctor, which is fundamentally distinct from Applicants' batching approach.

Similarly, Freeman does not show or suggest billing an employee for the aggregate of all services provided over a predetermined period, nor for billing an employee for the aggregate of all services received by all family members over a time period. Instead, Freeman describes billing the patient for each claim. "The explanation of benefits is also mailed to the patient, and acts as a bill for the patient's share of the claim. In step 114, the patient and the insurance company each pay their share of the claim amount to the bank." Col. 8, lines 32-35. (Emphasis added.)

Still further, Freeman does not show or suggest the aggregation of claims for the employer to pay the administrator. According to the Examiner's interpretation, the insurance company in Freeman and the employer in Applicants' system are analogous. As quoted above, Freeman describes that ". . .the insurance company . . . pay[s] [its] share of the claim amount to the bank." Col. 8. Lines 32-35. (Emphasis added.)

Each of Applicants' independent claims recites one or more aspects of claim aggregation that are not described or suggested by Freeman, and therefore are patentably distinct:

Claim 1 recites:

> . . . a payment process for paying an aggregate batch of provider claims for services delivered during a predetermined time period to an employee from an aggregate fund. . .

Claim 2 recites:

> . . .executing a payment process for paying a provider for an aggregate batch of provider claims for all services delivered by the provider to an employee during a predetermined time period, said payment being made from an aggregate fund. . .

Claim 3 recites:

> . . . b.) said entity reporting to employer on a periodic basis the aggregate amount owed by employer for services rendered for the employer's employees during the period; c.) said entity reporting to patient on a periodic basis the amount owed by patient for provider services rendered during a predetermined period of time. . .

Claim 6 recites:

> . . . second means for processing data regarding employers, their employees and the aggregate of services provided for a particular employer's employees by healthcare providers during a predetermined time period; and third means for processing data regarding all services rendered during a predetermined time period for each employee, including all people covered under employee's health plan. . .

Claim 13 recites:

> . . . a) aggregating all covered claims from providers resulting from service supplied over a predetermined period of time to the employee and the employee's family members; and
> b) generating a bill for the individual, said bill listing every service provided over the predetermined time period for the individual and related people and said bill providing a total amount due for the aggregated claim. . .

Claim 14 recites:

> . . . a) aggregating all claims from providers resulting from service supplied over a predetermined period of time to all persons covered by the plan; and
> b) generating a bill for the plan sponsor, said bill identifying a total amount due from the sponsor for the aggregated claims. . .

Each dependent claim is submitted to be patentably distinct for the reasons discussed above with respect to its corresponding independent claim. In additional, each dependent claims recite features which lead to further advantage.

Change in Correspondence Address

Under separate cover, the Applicants' attorney has submitted a request to change the correspondence address for this application. Future correspondence should be sent to:

Beck & Tysver, P.L.L.C.
2900 Thomas Ave. South, Suite 100
Minneapolis, MN 55416-4477

CONCLUSION

The Applicants respectfully submit that this application is in condition for allowance. A notice to that effect is earnestly solicited. The Examiner is invited to contact the Applicants' representative at the below-noted telephone number if allowance of this case would be assisted thereby.

Respectfully submitted,
HEALTHEZ, INC.
By its attorneys:

Date: 3/27/01

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WHAT IS CLAIMED IS:

1. (Amended)A computerized system for tracking healthcare services, making payment to providers for services, and collecting payment from employers and employees for such services, comprising:

a) a payment process for paying an aggregate batch of provider claims for services delivered during a predetermined time period to an employee from an aggregate fund;

b) a primary funding process coupled to said payment process for replenishing funds disbursed by said payment process, by receiving funds from the employee's employer and depositing said funds in said aggregate fund;

c) a secondary funding process coupled to said payment process for receiving employee contribution funds said funds payable to said aggregate fund; and

d) a tertiary funding process coupled to said payment process for acquiring funds from a credit source to complete employee contribution funds.

2. (Amended) A method for tracking healthcare services, making payment to providers for services, and collecting payment from employers and employees for such services, comprising the steps of:

a) executing a payment process for paying a provider for an aggregate batch of provider claims for all services delivered by the provider to an employee during a predetermined time period, said payment being made from an aggregate fund;

b) executing a primary funding process coupled to said payment process for replenishing funds disbursed by said payment process, by receiving funds from the employee's employer and depositing said funds in said aggregate fund;

c) executing a secondary funding process coupled to said payment process for receiving employee contribution funds said funds payable to said aggregate fund;

d) executing a tertiary funding process coupled to said payment process for acquiring funds from a credit source to complete employee contribution funds.

3. (Amended) A method of health benefit payment and reporting, comprising the steps of:

a) provider reporting to a first entity the provision of services to a patient;

b.) said entity reporting to employer on a periodic basis the aggregate amount owed by employer for services rendered for the employer's employees during the period;

c.) said entity reporting to patient on a periodic basis the amount owed by patient for provider services rendered during a predetermined period of time;

d.) collecting payment from the employer;

e.) said entity paying said provider for services within a predetermined time period after the provisions of services~~;~~, regardless of whether the entity has received payment from said patient; and

f.) collecting payment from the patient.

4. A method of benefit payment and reporting according to claim 3, wherein said entity extends credit to said patient, such that said patient can pay the provider bills in installments, said installments being paid to said entity.

5. (Amended) A method of benefit payment and reporting according to claim 4, wherein said entity calculates the risk associated with extending credit to patients, and incorporates the risk into the pricing of its services to employers and ~~physicians~~providers.

6. A data processing system for managing the reporting of services provided and the payment and collection associated with the provision of healthcare services by a healthcare provider to an employee of an employer who provides a health plan for employees, comprising:

a.) computer processor means for processing data;

b.) storage means for storing data on a storage medium;

c.) first means for processing data regarding services provided by a healthcare provider to a patient;

d.) second means for processing data regarding employers, their employees and the aggregate of services provided for a particular employer's employees by healthcare providers during a predetermined time period;

e.) third means for processing data regarding all services rendered during a predetermined time period for each employee, including all people covered under employee's health plan.

7. (Amended) A data processing system according to claim 6, further comprising;

f.) fourth means for generating a report to employer stating the amount owed for the aggregate of all services provided to employees during a predetermined time period;

g.) fifth means for generating a report to employees identifying all services provided by all health care providers for all people covered by the health plan for each employee, and stating an amount owed by employee.

8. (Amended) A data processing system according to claim 6, further comprising:

f.) ~~fourth~~ sixth means for making payment to a healthcare provider for services rendered for an employer's employee within two weeks of the provision of services;

g.) ~~fifth~~ seventh means for processing data regarding amounts owed to and paid to provider.

9. (New) A system according to claim 1, further comprising a claim aggregation process by which all claims for services rendered to all employees and their family members by all providers during a predetermined period of time are aggregated and a list is generated for each family of all such services with an identification of the aggregate amount owed by said family.

10. (New) A system according to claim 1, further comprising a claim aggregation process by which all claims for services rendered to all employees and their family members by all providers during a predetermined period of time are aggregated and a total amount is identified that is payable by the employer for the aggregated claims.

11. (New) A method according to claim 2, further comprising the step of aggregating all claims for services rendered to an employees and their family members by all providers during a predetermined period of time and identifying a total amount payable by the employee for the aggregate claims.

12. (New) A method according to claim 2, further comprising the step of aggregating all claims for services rendered to all employees and their family members by all providers during a predetermined period of time and identifying a total amount payable by the employer for the aggregate claims.

13. (New) A method of administering a healthcare plan that covers an individual and other people related to the individual in a predefined manner, comprising the steps of:

a) aggregating all covered claims from providers resulting from service supplied over a predetermined period of time to the employee and the employee's family members; and

b) generating a bill for the individual, said bill listing every service provided over the predetermined time period for the individual and related people and said bill providing a total amount due for the aggregated claims.

14. (New) A method of administering a healthcare plan, comprising the steps of:

a) aggregating all claims from providers resulting from service supplied over a predetermined period of time to all persons covered by the plan; and

b) generating a bill for the plan sponsor, said bill identifying a total amount due from the sponsor for the aggregated claims.